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DIVISION OF PUBLIC HEALTH

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MEMORANDUM 2018-3

TO: Local Health Directors and TB Nurses

FROM: Jason Stout, MD, MHS
Medical Director
NC TB Control Program

DATE: October 26, 2018

RE: Changes to the NC TB Control Policy Manual

The TB manual has been revised and updated in accordance with current evidence-based practice. A number of revisions have been made and are summarized below. These changes have been posted to our website (<https://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html>).

Chapter II	Page 1	Updated current tests available for latent tuberculosis. Advised use of interferon gamma release assays in most patient populations, where feasible
	Page 1	IGRA's (QuantiFeron Gold and T-spot) can now be used for children over 2 years instead of 5 years old.
	Page 6	Clarified that two-step testing is not necessary with IGRAs
Chapter III	Page 2	Clarified that children under 5 should have both a lateral and posterior-anterior chest film
	Page 3	Added that TB nurses must only have standing orders for one regimen. If a different regimen is needed the physician should be consulted for an alternate regimen.
	Pages 3-6	Shorter course therapy should be used whenever possible when treating latent TB infection (LTBI). Isoniazid and

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Rifapentine for 3 months and Rifampin for four months are now preferred over Isoniazid for 9 months for the treatment of LTBI, except when these regimens are contraindicated due to allergy, adverse drug reactions, or drug intolerance.

With the approval of the local clinician, self-administered Isoniazid and Rifapentine is acceptable. Directly observed preventive therapy (DOPT) should be reserved for persons at high risk for progression to TB disease and who are less likely to complete self-administered therapy.

The rifampin dosage for children (under 15 years) is now 15 mg/kg.

	Page 8, 1.d.	Added that if a patient has an adverse reaction to the treatment of LTBI that results in the patient being hospitalized or dies this must be reported to the CDC National Surveillance for Severe Reactions (NSSAE) By sending an e-mail to them at LTBIdrugevents@cdc.gov
	Page 12	Updated the sample standing orders. The health department should only have one option for standing orders for the treatment of LTBI. If the patient is unable to take the regimen in the standing order the physician/provider will need to give a specific order for an alternate regimen. Standing orders can now be used in children under 5
Chapter IV	Page 6	Clarified that thrice-weekly DOT is acceptable after the First two weeks of daily therapy for infants and children with limited disease. Twice-weekly DOT is acceptable only if approved by the state pediatric TB consultant or state TB medical director.
	Page 7	Clarified that HIV-negative, non-pregnant adults with smear- and culture-negative TB should receive thrice-weekly therapy during the continuation phase
Chapter VII	Page 1	Added some clarification about how many hours of exposure constitutes a medium priority contact.
	Page 4 & 9	Reminder that a contact summary wizard must be completed on each contact in NCEDSS within 30 days of being identified.
	Page 5	Added that the regional TB nurse consultant should be contacted when family refuses window period prophylaxis for contacts less than 5 years of age.
Chapter IX	Page 1-6	Updated the ALA incentive fund application forms and policy. The check can no longer be written directly to the nurse. It must be written to the health department and the

- ALA must have a copy of a completed W-9 form from the health department on file.
- Pages 32-34 Updated clinical pathway regarding giving daily DOT for the first eight weeks and then may go to thrice weekly unless HIV positive, sputum smear positive
- Pages 44-48 Took out the outdated National Surveillance Form for Reporting adverse reactions to treatment of LTBI. This Should now be reported by e-mailing the CDC at LTBIdrugevents@cdc.gov (see chapter III, page 8, 1, d.)
- Page 54 Video DOT no longer must be approved by the regional TB nurse consultant and although in-person DOT is encouraged in children under 10 years, video DOT can be used when needed in patients as young as 5.